

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-046080

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11156

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		c. CITY OR TOWN Affton		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 8108 Mathilda		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Stein						4. DATE OF DEATH Month Day Year November 11 1963					
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/29/1900		9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY bookkeeper		11. BIRTHPLACE (City and state or country) St. Louis, Mo.				12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Henry Stein				13b. MOTHER'S MAIDEN NAME Dora Wolz				14. NAME OF HUSBAND OR WIFE Hazel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW-1				16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT Address Hazel Stein 8108 Mathilda					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Overseas of abdominal aorta</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic vascular disease</i> DUE TO (c) <i>451X</i>										INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <i>10/8/63</i> to <i>11/11/63</i> and last saw him alive on <i>11/10/63</i> Death occurred at <i>4 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated											
22a. SIGNATURE <i>D. N. Schmeidler MD</i> (Degree or title)						22b. ADDRESS <i>6817 Gravois</i>			22c. DATE SIGNED <i>11/11/63</i> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11/13/1963		23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		23d. LOCATION (City, town, or county) St. Louis County, Mo.					
24. FUNERAL DIRECTOR John L. Ziegenhein & Sons 7027 Gravois						25. DATE RECD. BY LOCAL REG. NOV 12 1963		26. REGISTRAR'S SIGNATURE <i>Roald Smith MD</i>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Donald B. [Signature]

Licensed Embalmer No. _____

P. O. Address _____

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.